STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING _____ B. WING _____	C 04/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00146601.

Complaint IN00146601- Substantiated. No deficiencies related to the allegations are cited.

Survey Dates: March 31, and April 1, 2014

Facility number: 000476
Provider number: 155446
AIM number: 100290870

Survey team:
Christine Fodrea, RN

Census bed type:
SNF/NF: 120
Total: 120

Census payor type:
Medicare: 21
Medicaid: 70
Other: 29
Total: 120

Sample: 6

Covington Manor Health and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00146601.

Quality Review 04/02/14 by Lisa McColly

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE